University Women's Health Specialists John A Burns School of Medicine Faculty Practice Women's Option Center Medical Screening Questionnaire	**Name:** **Date of Birth:**
Name of doctor who referred you to our offices (if applicable) or name of primary ob-gyn:	Would you like for us to send records of your visit today to your referring doctor or primary ob-gyn? (circle one) **YES** **NO**

Please help us understand your medical history by answering the following questions:

Yes	No	Have you ever experienced (select all that apply):
		Heart problems
		Asthma or lung problems
		Kidney problems
		Bleeding or clotting problems
		Anemia
		Diabetes
		Seizures
		Migraines
		Depression, anxiety or bipolar disorder
		Other problems that you see a doctor for?
If YES, please describe these other medical problems:		

Yes	No	
		Has anyone recently hurt or threatened you?
		Do you drink alcohol daily or more than 3 alcoholic drinks at a time?
		Have you smoked cigarettes within the last year?
Have you used <u>any</u> of these drugs in the last 3 years?		
		Meth, cocaine, crack, heroin or any other illegal drugs?
		Narcotic pain pills

Yes	No	Have you ever had surgery?
If yes, please describe the type of surgery and date:		

Yes	No	Have you ever stayed overnight in a hospital, other than for deliveries or surgeries?
If yes, please describe why you had to stay in the hospital:		

How many pregnancies have you had?	
	Number of vaginal deliveries
	Number of C-sections
	Number of miscarriages
	Number of abortions
	Number of ectopic, tubal, molar or other abnormal pregnancies

Yes	No	Have you ever had any of the following?
		Gonorrhea
		Chlamydia
		Genital Warts
		Genital Herpes
		Pelvic inflammatory disease (PID)
		Other sexually transmitted disease
		Abnormal pap smear
		Have you ever been tested for HIV?
What was the result of the HIV test? (please circle one) **Negative** **Positive** **Don't Know**		

Please list any **medications** that you have taken within the last month:

Yes	No	
		Are you **allergic** to any medications? Please list:
		Are you allergic to **latex**?

What birth control methods have you **used in the past**? (please circle)

Pills	Shot (Depo-Provera)	IUD
Patch (Ortho-Evra)	Morning after pill	Diaphragm
Vaginal Ring (Nuva Ring)	Implant (Implanon, Nexplanon, Norplant)	Condoms

What birth control methods **are you interested in today**? (please circle)

Pills	Shot (Depo-Provera)	IUD
Patch (Ortho-Evra)	Morning after pill	Diaphragm
Vaginal Ring (Nuva Ring)	Implant (Implanon, Nexplanon, Norplant)	Condoms

Reason for this termination (check all that apply):	
Do not desire pregnancy	
Incomplete miscarriage, fetal anomaly, or fetal death	
Rape/Assault	
Concerns about your health	
Other (please describe):	

What was the first day of your last menstrual period?	

Do you feel you need help in making a decision about whether to have an abortion or continue your pregnancy?

Yes No

Some patients want to see their ultrasound, while others do not. We are happy to do either for you. If you have an ultrasound done today, would you like the opportunity to view it?

Yes No

Some patients prefer not to know if the doctor finds anything unusual or abnormal about this pregnancy, such as if there are twins or if there is a problem with the pregnancy. If the doctor finds anything unusual or abnormal, would you like to be told about it?

Yes No

For some early pregnancies, medications can be used to cause cramping and bleeding to pass the pregnancy at home. Would you be interested in this option instead of a surgical abortion (also called a D&C)?

Yes No Maybe

Patient signature: _____ Date:_____

Reviewed by:_____ Date: _____